FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040436

Facility Name: STERLING PAVILION, LTD.

Address: 105 E. 23RD STREET (Number) STERLING (City) 61081 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-4264 **Fax #** (815) 626-3254

IDPA ID Number: 36-3873072

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	RICHARD S. SGARLATA, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,286	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,495	5,106	2,282	12,883	8
9	SNF/PED					9
10	ICF	18,549	6,135		24,684	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,044	11,241	2,282	37,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.83%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,282

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	131,021	11,693	7,080	149,794		149,794		149,794			1
2	Food Purchase		154,986		154,986		154,986	(1,413)	153,573			2
3	Housekeeping	108,110	19,952		128,062		128,062	(247)	127,815			3
4	Laundry	43,339	26,554		69,893		69,893		69,893			4
5	Heat and Other Utilities			111,593	111,593		111,593	534	112,127			5
6	Maintenance	41,702	36,319	39,105	117,126		117,126	498	117,624			6
7	Other (specify):*							445	445			7
8	**TOTAL General Services**	324,172	249,504	157,778	731,454		731,454	(183)	731,271			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,122,882	47,945	1,800	1,172,627		1,172,627	(681)	1,171,946			10
10a	Therapy			10,745	10,745		10,745		10,745			10a
11	Activities	45,862	3,901		49,763		49,763		49,763			11
12	Social Services	40,175		3,690	43,865		43,865		43,865			12
13	Nurse Aide Training			839	839		839	82	921			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,208,919	51,846	17,074	1,277,839		1,277,839	(599)	1,277,240			16
	C. General Administration											
17	Administrative	60,252			60,252		60,252	128,222	188,474			17
18	Directors Fees											18
19	Professional Services			185,215	185,215		185,215	(153,852)	31,363			19
20	Dues, Fees, Subscriptions & Promotions			35,153	35,153		35,153	(30,137)	5,016			20
21	Clerical & General Office Expenses	34,881	4,168	29,937	68,986		68,986	32,787	101,773			21
22	Employee Benefits & Payroll Taxes			253,463	253,463		253,463		253,463			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,327	1,327		1,327	432	1,759			24
25	Other Admin. Staff Transportation			1,479	1,479		1,479	(62)	1,417			25
26	Insurance-Prop.Liab.Malpractice			76,384	76,384		76,384	505	76,889			26
27	Other (specify):*							14,022	14,022			27
28	**TOTAL General Administration**	95,133	4,168	582,958	682,259		682,259	(8,083)	674,176			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,628,224	305,518	757,810	2,691,552		2,691,552	(8,865)	2,682,687			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STERLING PAVILION, LTD.
0040436
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #		
22	EMPLOYEE BENEFITS	_____
2	FOOD	_____

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	_____
19	PROFESSIONAL FEES	_____

To reclass cost of appealing real estate taxes

Facility Name & ID Number STERLING PAVILION, LTD. #0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			53,730	53,730		53,730	206,273	260,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,176	15,176		15,176	670,331	685,507			32
33	Real Estate Taxes			28,961	28,961		28,961	1,256	30,217			33
34	Rent-Facility & Grounds			641,647	641,647		641,647	(641,647)				34
35	Rent-Equipment & Vehicles			6,153	6,153		6,153	5,223	11,376			35
36	Other (specify):*							6,667	6,667			36
37	**TOTAL Ownership**			745,667	745,667		745,667	248,103	993,770			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,489	117,248	174,737		174,737	(977)	173,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):*	1,332			1,332		1,332	(1,332)				43
44	**TOTAL Special Cost Centers**	1,332	57,489	183,678	242,499		242,499	(2,309)	240,190			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,629,556	363,007	1,687,155	3,679,718		3,679,718	236,929	3,916,647			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,754	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(461)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(380)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,685)	20		28
29	Other-Attach Schedule	(10,486)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,249)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	265,178		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 265,178		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 236,929		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

STERLING PAVILION, LTD.

ID# 0040436

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	PRIOR YEAR BLDG MAINTENANCE	(569)	6	2
3	PRIOR YEAR MAINTENANCE & REPAIR	(564)	6	3
4	PRIOR YEAR LEGAL	(235)	19	4
5	PRIOR YEAR NURSING & MED. RECORDS	(575)	10	5
6	PRIOR YEAR HOUSEKEEPING SUPPLIES	(88)	3	6
7	PRIOR YEAR CLERICAL & GENERAL EXPENSES	(57)	21	7
8	TRUST FEES	(150)	20	8
9	MARKETING SALARY	(1,332)	43	9
10	COLLECTION FEES	(217)	21	10
11	DISCOUNTS EARNED	(952)	2	11
12	MARKETING TRAVEL	(82)	25	12
13	INTEREST INCOME	(22)	32	13
14	POLITICAL CONTRIBUTIONS	(1,500)	21	14
15	REBATE FOR MAINTENANCE SUPPLIES	(159)	3	15
16	CAPITALIZED REPAIRS & MAINTENANCE	(3,984)	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(10,486)		90

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number STERLING PAVILION, LTD. **#** 0040436 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,413)											(1,413)	2
3	Housekeeping	(247)											(247)	3
4	Laundry													4
5	Heat and Other Utilities			534									534	5
6	Maintenance	(5,117)		2,726	2,889								498	6
7	Other (specify):*			77		368							445	7
8	**TOTAL General Services**	(6,777)		3,337	2,889	368							(183)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(575)							(106)				(681)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			82									82	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(575)		82					(106)				(599)	16
	C. General Administration													
17	Administrative				128,222								128,222	17
18	Directors Fees													18
19	Professional Services	(235)		(153,617)									(153,852)	19
20	Fees, Subscriptions & Promotions	(30,826)	150	539									(30,137)	20
21	Clerical & General Office Expenses	(2,154)		32,237	2,704								32,787	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			432									432	24
25	Other Admin. Staff Transportation	(82)		20									(62)	25
26	Insurance-Prop.Liab.Malpractice			505									505	26
27	Other (specify):*			4,273		9,749							14,022	27
28	**TOTAL General Administration**	(33,297)	150	(115,611)	130,926	9,749							(8,083)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,649)	150	(112,192)	133,815	10,117			(106)				(8,865)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	13,754	190,287	2,232									206,273	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22)	668,740	1,613									670,331	32
33	Real Estate Taxes			1,256									1,256	33
34	Rent-Facility & Grounds		(641,647)										(641,647)	34
35	Rent-Equipment & Vehicles			5,223									5,223	35
36	Other (specify):*		6,667										6,667	36
37	**TOTAL Ownership**	13,732	224,047	10,324									248,103	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(977)				(977)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,332)											(1,332)	43
44	**TOTAL Special Cost Centers**	(1,332)							(977)				(2,309)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,249)	224,197	(101,868)	133,815	10,117			(1,083)				236,929	45

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				STERLING BUILDING PAVILION, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 641,647	STERLING BUILDING PAVILION, L.L.C.		$	$ (641,647)	1
2	V	32	INTEREST EXPENSE		STERLING BUILDING PAVILION, L.L.C.		668,740	668,740	2
3	V	30	DEPRECIATION EXPENSE		STERLING BUILDING PAVILION, L.L.C.		190,287	190,287	3
4	V	36	AMORTIZATION EXPENSE		STERLING BUILDING PAVILION, L.L.C.		6,667	6,667	4
5	V	20	TRUST FEES		STERLING BUILDING PAVILION, L.L.C.		150	150	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 641,647			$ 865,844	$ * 224,197	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 534	$ 534	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		2,726	2,726	16
17	V	7	EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.		77	77	17
18	V	13	NURSES AIDE TRAINING		DYNAMIC HEALTH CARE CONS.		82	82	18
19	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		1,288	1,288	19
20	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		539	539	20
21	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		32,237	32,237	21
22	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		432	432	22
23	V	25	ADMIN. STAFF TRANS.		DYNAMIC HEALTH CARE CONS.		20	20	23
24	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.		505	505	24
25	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		4,273	4,273	25
26	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.		2,232	2,232	26
27	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.		1,613	1,613	27
28	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		1,256	1,256	28
29	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		5,223	5,223	29
30	V	19	HOME OFFICE	154,905	DYNAMIC HEALTH CARE CONS.			(154,905)	30
31	V	0							31
32	V	0							32
33	V	0							33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 154,905			$ 53,037	$ * (101,868)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 2,889	$ 2,889	15
16	V	10	NURSING CMP - SUE G.		DYNAMIC HEALTH CARE CONS.		0		16
17	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.		23,318	23,318	17
18	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.		29,899	29,899	18
19	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.		25,873	25,873	19
20	V	17	ADMIN. CMP. - A. STERN		DYNAMIC HEALTH CARE CONS.		18,855	18,855	20
21	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		0		21
22	V	17	ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.		5,509	5,509	22
23	V	17	ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		6,186	6,186	23
24	V	17	ADMIN. CMP. - E. CASSON		DYNAMIC HEALTH CARE CONS.		0		24
25	V	17	ADMIN. CMP. - S. BOGEN		DYNAMIC HEALTH CARE CONS.		0		25
26	V	17	ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.		6,808	6,808	26
27	V	17	ADMIN. CMP. - A. STEINER		DYNAMIC HEALTH CARE CONS.		2,223	2,223	27
28	V	17	ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.		9,551	9,551	28
29	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.		2,704	2,704	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 133,815	$ * 133,815	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 368	$ 368	15
16	V	15	EMP. BEN.- SUE G.		DYNAMIC HEALTH CARE CONS.		0		16
17	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.		651	651	17
18	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.		758	758	18
19	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.		3,192	3,192	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.		0		20
21	V	27	EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.		1,173	1,173	21
22	V	27	EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		1,018	1,018	22
23	V	27	EMP. BEN.- E. CASSON		DYNAMIC HEALTH CARE CONS.		0		23
24	V	27	EMP. BEN.- S. BOGEN		DYNAMIC HEALTH CARE CONS.		0		24
25	V	27	EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.		933	933	25
26	V	27	EMP. BEN.- A. STEINER		DYNAMIC HEALTH CARE CONS.		369	369	26
27	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		1,285	1,285	27
28	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.		370	370	28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,117	$ * 10,117	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		10A	THERAPY	$ 10,745	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 10,745	$	15
16	V		22	EMPLOYEE BENEFITS	(9,278)	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	(9,278)		16
17	V		39	ANCILLARY SERVICES	105,078	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	105,078		17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 106,545			$ 106,545	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		10	NURSING & MEDICAL SUPPLY	$ 6,421	PHARMCOR, L.L.C.	100.00%	$ 6,421	$	15
16	V		22	EMPLOYEE BENEFITS	458	PHARMCOR, L.L.C.	100.00%	458		16
17	V		39	ANICILLARY EXPENSE	51,390	PHARMCOR, L.L.C.	100.00%	51,390		17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 58,269			$ 58,269	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES, FEES & SUBSCRIPTIONS	$ 0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	$ 0	$	15
16	V	10	MEDICAL SUPPLIES	403	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	297	(106)	16
17	V	39	ANCILLARY EXPENSE	3,713	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	2,736	(977)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,116			$ 3,033	$ * (1,083)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURICE AARON	OWNER	ADMIN	22.23	SEE ATTACHED	2.4	4.82	DYNAMIC	$ 29,899	17-7	1
2	FRED AARON	OWNER	ADMIN	23.80	SEE ATTACHED	8.08	16.16	DYNAMIC	25,873	17-7	2
3	MARSHALL MAUER	OWNER	ADMIN	16.53	SEE ATTACHED	2.1	4.28	DYNAMIC	23,318	17-7	3
4	ABRAHAM STERN	OWNER	ADMIN	9.92	SEE ATTACHED	0.43	0.86	DYNAMIC	18,855	17-7	4
5	DIANIA MAGAFAS	OWNER	ADMIN	0.39	SEE ATTACHED	3.39	7.53	DYNAMIC	6,186	17-7	5
6	DENNIS NEHMER	OWNER	MAINTENANCE	0.39	SEE ATTACHED	2.14	5.36	DYNAMIC	2,889	06-7	6
7	SUE KOPLIN	OWNER	ADMIN	0.39	SEE ATTACHED	3.66	8.13	DYNAMIC	5,509	17-7	7
8	SHARON AARON	RELATIVE	CLERICAL		SEE ATTACHED	2.14	5.36	DYNAMIC	2,704	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 115,233		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	707,726	15	$ 10,055	$ 16,071	37,567	$ 534	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	707,726	15	51,362		37,567	2,726	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	707,726	15	1,448		37,567	77	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	707,726	15	1,550		37,567	82	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	707,726	15	24,272		37,567	1,288	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	707,726	15	10,163		37,567	539	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	707,726	15	607,305	465,093	37,567	32,237	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	707,726	15	8,134		37,567	432	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	707,726	15	372		37,567	20	9
10	26	INSURANCE	PATIENT DAYS	707,726	15	9,517		37,567	505	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	707,726	15	80,498		37,567	4,273	11
12	30	DEPRECIATION	PATIENT DAYS	707,726	15	42,057		37,567	2,232	12
13	32	INTEREST	PATIENT DAYS	707,726	15	30,386		37,567	1,613	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	707,726	15	23,654		37,567	1,256	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	707,726	15	98,401		37,567	5,223	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,163		$ 53,037	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	54,000	54,000	2	2,889	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,209	32,209			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	14	435,842	435,842	2	23,318	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	14	558,156	558,156	2	29,899	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	50	7	160,040	160,040	8	25,873	5
6	17	ADMIN. CMP. - A. STERN	WGHTD. AVG. HOURS	8	14	351,664		0	18,855	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	179,079	179,079			7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	10	67,732	67,732	4	5,509	8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	10	82,127	82,127	3	6,186	9
10	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	45	2	47,882	47,882			10
11	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	119,320	119,320			11
12	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	14	126,974	126,974	3	6,808	12
13	17	ADMIN. CMP. - A. STEINER	WGHTD. AVG. HOURS	45	14	41,511	41,511	2	2,223	13
14	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	14	178,292	178,292	2	9,551	14
15	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	14	50,548	50,548	2	2,704	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,711		$ 133,815	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		6,887		2	368	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		2,883				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		12,175		2	651	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		14,155		2	758	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	50		19,744		8	3,192	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		18,514				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		14,423		4	1,173	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		13,516		3	1,018	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	45		10,284				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		7,029				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		17,400		3	933	11
12	27	EMP. BEN.- A. STEINER	WGHTD. AVG. HOURS	45		6,891		2	369	12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		23,984		2	1,285	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		6,917		2	370	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 10,117	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						10,745	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						(9,278)	2
3	39	ANCILLARY SERVICES	DIRECT ALLOCATION						105,078	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 106,545	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						6,421	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						458	2
3	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						51,390	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 58,269	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION							1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						297	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						2,736	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,033	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MANUFACTURERS BANK		X	LINE OF CREDIT			$	$ 195,000			$ 13,416	1
2	MANUFACTURERS BANK		X	NOTE PAYABLE				36,878			1,760	2
3	STERLING PAVILION		X	CAPITALIZED LEASE				6,701,139			668,740	3
4	BUILDING, L.L.C.											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,933,017			$ 683,916	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(22)	10
11	DYNAMIC ALLOCATION										1,613	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,591	14
15	TOTALS (line 9+line14)						$	$ 6,933,017			$ 685,507	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (22)	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (22)	21

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	30,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,217	2
3. Under or (over) accrual (line 2 minus line 1).	$	217	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	30,217	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	29,785	8
	1996	29,705	9
	1997	29,954	10
	1998	29,403	11
	1999	28,961	12

REAL ESTATE TAX ACCRUAL CALCULATION:

1999 TAX $28,961.44 X 103% = $30,000

DYNAMIC ALLOCATION = $1,256

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior BRICK Frame STEEL/CONCRETE Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 6,498
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 48,888	1
2	STERLING BUILDING, L.L.C. ALLOCATION			100,000	2
3	TOTALS			$ 148,888	3

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 6,052,408	$ 155,190	35	$ 172,926	$ 17,736	$ 1,002,269	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	18,723	544	20	938	394	7,129	9
10	Various			1994	6,356	164	20	319	155	2,101	10
11	Various			1995	13,538	347	20	677	330	3,602	11
12	SEWER WORK			1996	17,750	1,278	20	888	(390)	3,700	12
13	REPAIR PIPES FOR SEW			1996	1,442	37	20	72	35	300	13
14	WATER PUMP			1996	600	15	20	30	15	128	14
15	2 HOT WATER HEATER			1996	7,788	200	20	389	189	1,653	15
16	ALARM SYSTEM			1996	4,166	107	20	208	101	953	16
17	PLUMBING WORK			1996	1,889	48	20	94	46	470	17
18	2 GLASS DOORS 4 WIND			1997	1,886	48	20	94	46	368	18
19	INSTALLATION OF WALL			1997	6,250	160	20	313	153	1,252	19
20	REPAIR WATER MAIN			1997	1,166	30	20	58	28	222	20
21	FLOOR WORK			1997	3,325	85	20	166	81	636	21
22	DRIVEWAY REPAIR			1997	1,500	38	20	75	37	288	22
23	DUMPSTER AREA REP			1997	4,100	105	20	205	100	786	23
24											24
25	PAGE 12-1 REP TOTALS				23,547	604		673	69	4,934	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				11,922	106		301	195	301	32
33	PAGE 12C TOTALS				50,368	910		2,486	1,576	4,121	33
34	PAGE 12B TOTALS				76,025	1,548		3,804	2,256	8,021	34
35	PAGE 12A TOTALS				84,666	3,145		4,235	1,090	12,503	35
36	TOTAL (lines 4 thru 35)				$ 6,389,415	$ 164,709		$ 188,951	$ 24,242	$ 1,055,737	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSES STATION			1997	5,599	144	20	280	136	1,073	9
10	FLOOR WORK			1997	580	15	20	29	14	106	10
11	WALLPAPER			1997	1,375	35	20	69	34	247	11
12	HAND RAIL			1997	4,579	117	20	229	112	821	12
13	NURSING STATION			1997	5,600	144	20	280	136	980	13
14	PAINT & DECORATING			1997	8,053		20	403	403	806	14
15	REMODELING			1997	535	14	20	27	13	95	15
16	REMODELING			1997	6,932	178	20	347	169	1,215	16
17	REMODELING			1997	587	15	20	29	14	102	17
18	INSTALLATION OF DOOR			1997	4,583	118	20	229	111	706	18
19	PARKING LOT			1997	3,500	280	20	175	(105)	540	19
20	FLOOR TILE			1997	4,931	126	20	247	121	885	20
21	BATHROOM - REMODELIN			1998	2,635	68	20	132	64	286	21
22	HORN FOR DOOR			1998	912	23	20	46	23	119	22
23	LANDSCAPING			1998	3,000	257	20	150	(107)	388	23
24	FLOOR PATCH			1998	3,173	81	20	159	78	437	24
25	HANDRAIL			1998	2,134	55	20	107	52	303	25
26	VERTICAL BLINDS			1998	926	24	20	46	22	130	26
27	PARKING LOT			1998	7,500	641	20	375	(266)	1,063	27
28	GENERATOR			1998	1,899	49	20	95	46	285	28
29	FLOOR TILES			1998	3,145	81	20	157	76	419	29
30	PATIENT SIGNS			1998	3,318	85	20	166	81	374	30
31	LANDSCAPING			1998	3,000	257	20	150	(107)	375	31
32	LANDSCAPING			1998	3,000	257	20	150	(107)	388	32
33	CRASHRAIL			1998	180	5	20	9	4	24	33
34	HAND & CRASHRAIL			1998	2,545	65	20	127	62	286	34
35	LAMPS & FIXTURES			1998	445	11	20	22	11	50	35
36	TOTAL (lines 4 thru 35)				$ 84,666	$ 3,145		$ 4,235	$ 1,090	$ 12,503	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1998	983	84	20	49	(35)	114	9
10	HAND & CRASHRAIL			1998	2,133	55	20	107	52	241	10
11	FLOOR DRAIN			1998	2,850	73	20	143	70	358	11
12	DRYWALL			1998	582	15	20	29	14	70	12
13	COUNTER TOPS			1998	1,898	49	20	95	46	230	13
14	SLAB FOR WASHER			1998	2,350	60	20	118	58	295	14
15	TILES AND CARPETING			1998	8,877	228	20	444	216	1,110	15
16	LANDSCAPING			1998	700	60	20	35	(25)	82	16
17	LANDSCAPING			1998	585	50	20	29	(21)	60	17
18	COVE BASE			1998	420	11	20	21	10	46	18
19	FLOOR TILES			1998	2,468	63	20	123	60	338	19
20	DRYWALL			1998	576	15	20	29	14	65	20
21	PAINT & DECORATING			1998	21,004		20	1,050	1,050	2,100	21
22	CONCRETE WALS			1998	3,190	82	20	160	78	453	22
23	DRYWALL			1999	1,525	39	20	76	37	127	23
24	CONCRETE BLOCK WALLS			1999	3,142	81	20	157	76	314	24
25	WATER MAIN INSTALL			1999	238	6	20	12	6	15	25
26	ACTIVITY ROOM REMOD			1999	828	21	20	41	20	55	26
27	PIPES			1999	1,550	40	20	78	38	150	27
28	PIPES			1999	198	5	20	10	5	19	28
29	HANDRAIL			1999	2,393	61	20	120	59	220	29
30	ACTIVITY ROOM			1999	935	24	20	47	23	63	30
31	CEILING TILES			1999	601	15	20	30	15	60	31
32	ACT/NURSE STATION			1999	1,076	28	20	54	26	99	32
33	WATER TREATMENT SYS			1999	6,890	177	20	345	168	690	33
34	AIR CONDITIONER			1999	5,533	142	20	277	135	439	34
35	CAMERA SYSTEM			1999	2,500	64	20	125	61	208	35
36	TOTAL (lines 4 thru 35)				$ 76,025	$ 1,548		$ 3,804	$ 2,256	$ 8,021	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ACT/NURSE STATION			1999	2,500	64	20	125	61	229	9
10	TILING			1999	3,513	90	20	176	86	249	10
11	DRAPES			1999	2,117	54	20	106	52	141	11
12	TILE			1999	135	3	20	7	4	13	12
13	GAS WATER HEATER			1999	8,935	229	20	447	218	894	13
14	ACT/NURSE STATION			1999	1,128	29	20	56	27	103	14
15	PARKING BLOCKS			1999	1,025		20	51	51	68	15
16	PAINTING			1999	875		20	44	44	84	16
17	WATER SERVICE			1999	98	3	20	5	2	7	17
18	REMODELING			1999	1,154	30	20	58	28	73	18
19	NURSES STATION			1999	6,244	160	20	312	152	364	19
20	DYNALOCK SYSTEM			1999	4,966	127	20	248	121	475	20
21	LANDSCAPING			1999	705		20	35	35	70	21
22	PIPES			1999	526	13	20	13		24	22
23	WATER SERVICE			1999	2,469	63	20	123	60	164	23
24	WALLPAPER			1999	5,367		20	268	268	514	24
25	WATER MAIN REPLACE			1999	940	24	20	47	23	59	25
26	WALLPAPER			1999	885		20	44	44	84	26
27	WALLPAPER			1999	880		20	44	44	66	27
28	WALLPAPER			1999	690		20	35	35	50	28
29	WALLPAPER			1999	1,729		20	86	86	129	29
30	GENERATOR			1999	579		20	29	29	58	30
31	OVEN REPAIR			1999	613		20	31	31	57	31
32	FIRE ALARM			1999	560		20	28	28	51	32
33	PLUMBING			1999	595		20	30	30	40	33
34	COVE BASE			1999	339		20	17	17	33	34
35	WALL			1999	801	21	20	21		22	35
36	TOTAL (lines 4 thru 35)				$ 50,368	$ 910		$ 2,486	$ 1,576	$ 4,121	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL THERMOSTAT			2000	1,856	22	20	47	25	47	9
10	MIRRORS			2000	481	12	20	24	12	24	10
11	CUBICLE CURTAINS			2000	1,036	19	20	39	20	39	11
12	COUNTER TOPS			2000	485	8	20	16	8	16	12
13	FLOOR TILES			2000	549	9	20	18	9	18	13
14	PAINTING & DECOR			2000	3,035		20	76	76	76	14
15	FREEZER DOOR & FRAME			2000	1,153	1	20	5	4	5	15
16	NURSE STATION CAMERA			2000	1,975	19	20	41	22	41	16
17	DRYWALL			2000	490	8	20	17	9	17	17
18	DRYWALL			2000	862	8	20	18	10	18	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,922	$ 106		$ 301	$ 195	$ 301	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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21											21
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23											23
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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23											23
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	DYNAMIC	$ 23,547	$ 604	35	$ 673	$ 69	$ 4,934	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 23,547	$ 604		$ 673	$ 69	$ 4,934	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 552,710	$ 60,880	$ 56,360	$ (4,520)		$ 329,278	37
38	Current Year Purchases	57,938	11,410	3,170	(8,240)		3,170	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 610,648	$ 72,290	$ 59,530	$ (12,760)		$ 332,448	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	BUSINESS	FORD, ELDERADO 2000	2000	$ 45,441	$ 9,088	$ 11,360	$ 2,272	3	$ 11,360	42
43										43
44										44
45										45
46	TOTALS			$ 45,441	$ 9,088	$ 11,360	$ 2,272		$ 11,360	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 7,194,392	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 246,087	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 259,841	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,754	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,399,545	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

STERLING PAVILION, LTD.
0040436
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
STERLING PAVILION, LTD.	176,802	24,496	19,999	(4,497)	75,058
DYNAMIC HEALTHCARE	12,908	1,287	1,264	(23)	6,124
STERLING PAVILION BUILDING, L.L.C.	363,000	35,097	35,097		248,096
TOTALS	552,710	60,880	56,360	(4,520)	329,278
LINE 29: CURRENT YEAR					
STERLING PAVILION, LTD.	57,043	11,231	3,125	(8,106)	3,125
DYNAMIC HEALTHCARE	895	179	45	(134)	45
STERLING PAVILION BUILDING, L.L.C.					
TOTALS	57,938	11,410	3,170	(8,240)	3,170
LINE 30: FULLY DEPRECIATED					
STERLING PAVILION, LTD.					
DYNAMIC HEALTHCARE					
STERLING PAVILION BUILDING, L.L.C.					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
STERLING PAVILION, LTD.	233,845	35,727	23,124	(12,603)	78,183
DYNAMIC HEALTHCARE	13,803	1,466	1,309	(157)	6,169
STERLING PAVILION BUILDING, L.L.C.	363,000	35,097	35,097		248,096
TOTALS	610,648	72,290	59,530	(12,760)	332,448

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: STERLING PAVILION BUILDING, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		121	05/01/93	$ 641,647			3
4	Additions							4
5		STERLING PAVILION BUILDING, L.L.C.			(641,647)			5
6								6
7	TOTAL		121		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 04/01/1993
    Ending 04/01/2023

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 628,657
13.	12/31/2002	$ 628,657
14.	12/31/2003	$ 628,657

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,376 Description: PHOTOCOPIER=$430, STORAGE=$1620, DYNAMIC=$5223, CONCENTRATORS=$1269, WHIRLPOOL=$
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 796	$	$ 796
2	Books and Supplies		43		43
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		82		82
9	TOTALS	$	$ 921	$	$ 921
10	SUM OF line 9, col. 1 and 2 (e)	$ 921			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 40,526	$		$ 40,526	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,049			4,049	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			63,474			63,474	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				54,093		54,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				9,199	3,396		12,595	13
14	TOTAL			$		$ 117,248	$ 57,489		$ 174,737	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	MEDICAL SUPPLIES	3,396
2		
3		
4		
5		
6		
7		
8		
9		
10		
		3,396

	Outside Therapies (Column 5 - Other)	Amount
1	LABORATORY & XRAY	2,288
2	RENTALS	1,644
3	RADIOLOGY	5,267
4		
5		
6		
7		
8		
9		
10		
		9,199

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 128,466	$ 128,466	1
2	Cash-Patient Deposits	6,184	6,184	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	491,389	491,389	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,038	31,038	6
7	Other Prepaid Expenses	4,094	4,094	7
8	Accounts Receivable (owners or related parties)		17	8
9	Other(specify): See supplemental schedule	27,275	39,375	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 688,446	$ 700,563	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		6,052,408	14
15	Leasehold Improvements, at Historical Cos	314,062	314,062	15
16	Equipment, at Historical Cost	280,637	643,637	16
17	Accumulated Depreciation (book methods)	(191,209)	(1,538,930)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	106,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(49,834)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(229,900)	22
23	Other(specify): See supplemental schedule	229,990	229,990	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 633,480	$ 5,627,931	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,321,926	$ 6,328,494	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 91,001	$ 91,001	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,184	6,184	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,194	147,194	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,048	2,048	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable	1,301	1,301	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,933	4,933	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 282,661	$ 282,661	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	231,878	231,878	39
40	Mortgage Payable		6,701,139	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 231,878	$ 6,933,017	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 514,539	$ 7,215,678	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 807,387	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,321,926	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number STERLING PAVILION, LTD. **#** 0040436 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	26,093	26,093
Employee Loans	1,182	1,182
Option Deposit		12,100
	27,275	39,375

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Rent Security Deposit	229,900	229,900
Security Deposits	90	90
	229,990	229,990

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 665,500	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 665,500	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	141,887	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 141,887	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 807,387	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	STERLING PAVILION, LTD.	#	0040436	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		665,500
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		665,500
Equity(Deficit) from Page 17 Col 1		807,387
Related Party		
Equity(Deficit)	-1470373.7	
Income	-224197.23	
		(1,694,571)
Combined Equity - End of Year		(887,184)

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,761,267	1
2	Discounts and Allowances for all Levels	(505,668)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,255,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	449,430	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 449,430	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,140	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,220	19
20	Radiology and X-Ray	7,901	20
21	Other Medical Services	22,226	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 115,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,067	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,067	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,821,605	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	731,454	31
32	Health Care	1,277,839	32
33	General Administration	682,259	33
	B. Capital Expense		
34	Ownership	745,667	34
	C. Ancillary Expense		
35	Special Cost Centers	176,069	35
36	Provider Participation Fee	66,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,679,718	40
41	**Income before Income Taxes (line 30 minus line 40)****	141,887	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 141,887	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	115
2	Discounts Earned - (Adjusted out on Page 5)	952
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,067

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,633	1,739	$ 36,807	$ 21.17	1
2	Assistant Director of Nursing	841	857	14,080	16.43	2
3	Registered Nurses	8,425	9,196	140,354	15.26	3
4	Licensed Practical Nurses	22,716	24,569	316,806	12.89	4
5	Nurse Aides & Orderlies	65,704	69,284	601,717	8.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,009	2,091	23,798	11.38	9
10	Activity Assistants	3,201	3,391	22,063	6.51	10
11	Social Service Workers	3,529	3,816	40,175	10.53	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,179	21,443	9.84	13
14	Head Cook	4,016	4,188	27,709	6.62	14
15	Cook Helpers/Assistants	14,178	14,701	81,870	5.57	15
16	Dishwashers					16
17	Maintenance Workers	3,782	3,820	41,702	10.92	17
18	Housekeepers	13,525	14,576	108,110	7.42	18
19	Laundry	6,549	6,788	43,339	6.38	19
20	Administrator	2,059	2,270	60,252	26.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,609	3,942	34,881	8.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,795	1,984	13,118	6.61	31
32	Other Health Care(specify)					32
33	Other(specify) SEE SUPP	104	120	1,332	11.10	33
34	TOTAL (lines 1 - 33)	159,667	169,511	$ 1,629,556 *	$ 9.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	163	$ 7,080	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	270	9,450	10A-3	40
41	Occupational Therapy Consultant	37	1,295	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	65	3,690	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	631	$ 23,315		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING	104	120	$ 1,332	$ 11.10
	104	120	$ 1,332	$ 11.10

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RHONDA REED	ADMINISTRATOR	NONE	$ 60,252
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,252

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BURKE, WARREN, MACKAY & SERRITELA, P.C.	LEGAL	$ 115
LITTLER MENDELSON	LEGAL	185
DYNAMIC H.C. CONSULTANTS	LEGAL	82
SACHNOFF & WEAVER, LTD	LEGAL	3,182
FROST, RUTTNEBERG & ROTHBLATT, P.C.	ACCOUNTING	18,439
HEALTH DATA SYSTEMS, INC	DATA PROCESSING	2,536
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	3,592
ECONOCARE	PURCHASING SERVICES	2,178
DYNAMIC HEATHCARE	BOOKKEEPING SERVICES	154,905
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 185,215

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,678
Unemployment Compensation Insurance	14,715
FICA Taxes	123,522
Employee Health Insurance	76,439
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	3,109
TOTAL (agree to Schedule V, line 22, col.8)	$ 253,463

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,868
Health Care Worker Background Check	
(Indicate # of checks performed 16)	112
YELLOW PAGE ADVERTISING	1,685
PROMOTIONAL ADVERTISING	28,991
LICENSES & FEES	613
DUES & SUBSCRIPTIONS	684
DYNAMIC ALLOCATION	539
Less: Public Relations Expense	( )
Non-allowable advertising	(28,991)
Yellow page advertising	(1,685)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,016

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,327
DYNAMIC ALLOCATION	432
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,759

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,199** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **66,429**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw